BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against:	)	
DONOVAN JOHN ANDERSON, M.D.	)	Case No. 800-2017-039881
Physician's and Surgeon's Certificate No. G 48061	)	
Respondent.	)	

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Douglas S. de Heras, Esq., on behalf of Donovan John Anderson, M.D., and the time for action having expired at 5:00 p.m. on May 24, 2019, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against:	
DONOVAN JOHN ANDERSON, M.D.	MBC No. 800-2017-039881
Physician's and Surgeon's Certificate No. G 48061	**ORDER GRANTING STAY**
	(Government Code Section 11521)
Respondent	

Douglas S. de Heras, Esq. on behalf of respondent, Donovan John Anderson, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of May 17, 2019, at 5:00 p.m.

Execution is stayed until May 24, 2019, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: May 16, 2019

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against:	)	
DONOVAN JOHN ANDERSON, M.D.	)	**Case No. 800-2017-039881**
Physician's and Surgeon's Certificate No. G 48061	)	
Respondent	)	

DECISION AND ORDER

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 17, 2019.

IT IS SO ORDERED April 17, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Ronald H. Lewis, M.D.
Ronald H. Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: DONOVAN JOHN ANDERSON, M.D., Physician's and Surgeon's Certificate No. G 48061 Respondent.	Case No. 800-2017-039881 OAH No. 2018120922

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on March 7, 2019, in Oakland, California.

Supervising Deputy Attorney General Mary Cain-Simon represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Attorney Douglas de Haras represented respondent Donovan John Anderson, M.D., who was present for the hearing.

The matter was submitted for decision on March 7, 2019.

FACTUAL FINDINGS

1. Respondent Donovan John Anderson, M.D., received Physician's and Surgeon's Certificate No. G 48061 on July 2, 1982. As of June 8, 2018, this certificate was active, and was scheduled to expire November 30, 2019. Respondent was on probation, as described in greater detail in Findings 8 and 9, below.

2. On November 20, 2018, acting in her official capacity as Executive Director of the Medical Board of California (Board), complainant Kimberly Kirchmeyer filed an accusation and petition to revoke probation against respondent. The accusation and petition allege that the Arizona Medical Board entered an order, effective January 11, 2018, imposing professional discipline against respondent in Arizona. The accusation and petition allege

further that respondent failed to disclose this Arizona disciplinary order to the Board on his quarterly probation report for the first calendar quarter of 2018. On these bases, complainant seeks revocation of respondent's probation, and of his certificate. Respondent requested a hearing.

Professional Experience and Certificate History

3. Respondent is trained in internal medicine. He has spent more than 35 years as a primary care physician and hospitalist in and around Needles, California, and Mohave Valley, Arizona.

4. In addition to his California certificate, respondent also holds License No. 13491 to practice medicine in Arizona.

5. The Arizona Medical Board reprimanded respondent's Arizona license in January 2004 for errors in medical care and in June 2006 for handling medical records improperly. The Board followed, reprimanding respondent's California certificate in April 2004 and in August 2007.

6. The Arizona Medical Board again reprimanded respondent's Arizona license for errors in medical care in June 2009. This reprimand led the Board to place respondent's California certificate on probation, effective in October 2009.

7. In August 2010, the Arizona Medical Board placed respondent on probation for one year, again for errors in medical care. As part of this probation, the Arizona Medical Board required respondent to take a refresher course in medical recordkeeping. Effective July 1, 2011, the Board continued respondent's California probation for three more years.

8. Effective January 10, 2014, the Board continued respondent's California probation for five more years. The Board took this action because respondent had committed gross and repeated negligence in patient care and had falsified medical records.

9. The order described in Finding 8 includes three conditions material to complainant's November 2018 accusation.

a. Condition 5 calls for respondent to obey "all federal, state[,] and local laws" and "all rules governing the practice of medicine in California."

b. Condition 6 calls for respondent to provide quarterly declarations, "under penalty of perjury on forms provided by the Board," describing his compliance with his probation conditions.

c. Condition 11 confirms that the Board may revoke respondent's probation, and with it his certificate, if he violates any of the probation conditions.

10. Effective April 6, 2017, the Arizona Medical Board placed respondent on probation for five years, because of the California disciplinary action described above in Findings 8 and 9. Respondent consented to entry of this order, signing the document memorializing this consent in March 2017.

11. Effective January 11, 2018, the Arizona Medical Board placed respondent on probation for 10 years. This order by the Arizona Medical Board permits respondent, for the duration of his Arizona probation, to "prescribe controlled substances only in an inpatient hospital or hospice setting, including prescribing discharge controlled substance medications to a patient for up to five days."

12. The Arizona Medical Board took the disciplinary action described in Finding 11 because of errors in medical care relating to an Arizona patient's controlled substance prescriptions. In particular, the Arizona Medical Board found that respondent

> deviated from [the] standard of care by failing to document all prescribers of controlled substances, by failing to have [the patient] enter into a pain agreement, by failing to perform urine drug screen monitoring, by failing to review the [Arizona Controlled Substance Prescription Monitoring Program] database, by failing to utilize non-controlled substance therapies, and by failing to obtain informed consent with the patient regarding the single use and interacting dangers of agents being prescribed.

Quarterly Reporting

13. Since he has been on probation in California, respondent has completed quarterly probation reports on Board forms. Each of these forms asks whether, during the preceding quarter, respondent has "had a license or certificate to practice a business or profession suspended, revoked, or surrendered or otherwise disciplined by any other federal, state, government agency or other country?" The form includes boxes for respondent to check either "yes" or "no" as his answer.

14. Respondent consistently has answered "no" to the question referenced in Finding 13. In particular, on his quarterly declaration for the first quarter of 2018, respondent answered this question "no."

15. Respondent testified that he did not realize when he completed his quarterly declaration for the first quarter of 2018 that the phrase "otherwise disciplined" in the question referenced in Finding 13 would encompass a probationary order. He stated further that he believed that he truthfully could say "no" to this question because the Arizona Medical Board had not revoked his Arizona medical license. This testimony is not credible. Respondent knowingly and intentionally failed to report the disciplinary action described in Finding 11 to the Board on his first quarter 2018 probation report.

Additional Evidence

16. Respondent's quarterly probation declarations to the Board for the first and second quarters of 2017 also denied that respondent had suffered license discipline during the preceding quarters. In fact, as described above in Finding 10, respondent consented to discipline in Arizona during the first quarter of 2017 and the Arizona Medical Board entered a disciplinary order against him during the second quarter of 2017.

17. During an interview with his probation monitor on March 20, 2018, respondent told the probation monitor that he had stopped prescribing opioid medications. He stated that he had made this decision because he did not want to contribute to the local "opioid epidemic." He did not disclose that the order described above in Finding 11 restricted his authority to prescribe controlled substances outside a hospital or hospice setting, or that it did so because of the matters described in Finding 12.

18. The California and Arizona orders described above in Findings 8, 10, and 11 required respondent to undertake additional medical education. Respondent has fulfilled these requirements, including a medical recordkeeping course; a five-day practice assessment through the Physician Assessment and Clinical Education Program at the University of California, San Diego; and additional annual continuing medical education.

19. The California order described above in Finding 8 requires respondent to have a practice monitor who reviews his work periodically, consults with him about opportunities for improvement, and makes quarterly reports to the Board about respondent's practice. Respondent's practice monitor is Edward Paget, M.D., a general surgeon. Dr. Paget has made regular, timely reports to the Board about respondent and has not identified any significant problems in respondent's practice during respondent's most recent California probation period.

20. Both respondent and Dr. Paget testified credibly that few physicians serve the rural, remote area where respondent practices. Poverty and chronic poor health are important problems in this community. Steve Lopez, the administrator of the hospital in which respondent works, corroborated this information; he, respondent, and Dr. Paget concurred as well that if respondent no longer could practice medicine, the community's shortage of medical providers would become even more acute.

LEGAL CONCLUSIONS

Accusation

1. The Board may suspend or revoke respondent's physician's and surgeon's certificate if clear and convincing evidence establishes the facts supporting discipline. The factual findings above reflect this standard.

2. Business and Professions Code sections 2227 and 2234 make a physician's unprofessional conduct grounds for suspension or revocation of the physician's certificate.

3. Unprofessional conduct includes dishonesty. (Bus. & Prof. Code, §§ 2261, 2234, subd. (e).) In light of the matters stated in Finding 11, the matters stated in Findings 13 through 15 constitute cause for discipline against respondent.

4. Unprofessional conduct also includes conduct occurring in another state and constituting cause for professional discipline in that state, if such conduct also would constitute cause for discipline in California. (Bus. & Prof. Code, §§ 141, 2305.) The matters stated in Findings 11 and 12 constitute cause for discipline against respondent.

Petition to Revoke Probation

5. The Board may revoke respondent's probation if a preponderance of the evidence establishes cause for revocation. Because the factual findings above reflect clear and convincing evidence, they meet this standard as well.

6. The matters stated in Findings 8 and 9 establish that the Board may revoke respondent's probation for violating any laws governing medical practice in Arizona. The matters stated in Finding 11 constitute cause to revoke respondent's probation.

7. The matters stated in Findings 8 and 9 establish that the Board may revoke respondent's probation for filing dishonest quarterly probation reports. In light of the matters stated in Finding 11, the matters stated in Findings 13 through 15 constitute cause to revoke respondent's probation.

Disciplinary Considerations

8. The matters stated in Finding 20 demonstrate respondent's value to a community with great medical needs, and explain the Board's prior efforts to improve respondent's practice rather than revoking his certificate. Despite reprimands and a lengthy probation, however, as summarized in Findings 5 through 12, respondent remains a risk to public health and welfare. Revocation of respondent's certificate is appropriate.

ORDER

1. The stay of revocation ordered effective January 10, 2014, for Physician's and Surgeon's Certificate No. G 48061, first issued to respondent Donovan J. Anderson on July 2, 1982, is lifted. The revocation of Physician's and Surgeon's Certificate No. G 48061 ordered effective January 10, 2014, is imposed.

2. Physician's and Surgeon's Certificate No. G 48061, first issued to respondent Donovan J. Anderson on July 2, 1982, is revoked.

DATED: March 22, 2019

DocuSigned by:
Juliet E. Cox
9409C6FCAB7C4CE...

JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
State Bar No. 113083
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3884
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation/Petition to Revoke Probation Against: **DONOVAN JOHN ANDERSON, M.D.** **8700 S. Highway 95** **P.O. Box 5878** **Mohave Valley AZ 86440-8519** **Physician's and Surgeon's Certificate No. G 48061** Respondent.	Case No. 800-2017-039881 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation and Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 2, 1982, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 48061 to DONOVAN JOHN ANDERSON, M.D. (Respondent). The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and will expire on November 30, 2019, unless renewed.

3. In a disciplinary action entitled "In the Matter of Accusation Against Donovan John Anderson, M.D." Case No. D1-2007-183501, the Medical Board of California, issued a decision,

effective January 10, 2014, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five years with certain terms and conditions. A copy of that decision is attached as Exhibit A and is incorporated by reference.

JURISDICTION

4. This Accusation and Petition to Revoke Probation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code provides that the Board shall take action against a licensee who is charged with unprofessional conduct.

7. Section 2234(e) of the Code provides that the Board shall take action against a licensee who is charged with unprofessional conduct including any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

9. Section 2305 of the Code states:

"The revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under

this chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

10. Section 141 of the Code states:

"(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein."

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

FACTS

11. On or about December 7, 2017, the Arizona Medical Board issued a Decree of Censure and Order. The Arizona Board's decree and order are based on factual findings and conclusions of law that Respondent engaged in unprofessional conduct as defined in Arizona Revised Statutes (A.R.S.) Sect. 32-1401(27) (e) (Failing or refusing to maintain adequate medical records on a patient") and Sect. 32-1401(27) (q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") The Arizona Board's Decree of Censure and Order includes factual findings that Respondent deviated from the standard of care in regard to prescribing controlled substances to his patients. These deviations comprise failure to document all prescribers of controlled substances, failure to have patients enter into pain management agreements, failure to perform urine drug screen monitoring, failure to consult the Controlled Substance Prescription Monitoring Program (CSPMP) database, failure to utilize non-controlled substance therapies, and failure to obtain informed consent regarding the single use

and interacting dangers of agents being prescribed to a patient. The Arizona Board moreover found that Respondent's conduct had resulted in actual harm to a patient.

12. The Arizona Medical Board's Decree of Censure and Order placed Respondent on probation for a period of ten years, effective January 11, 2018. A copy of the Arizona Medical Board's Decree of Censure and Order is attached as Exhibit B to this Petition to Revoke Probation.

13. In his April 10, 2018 Quarterly Declaration to the Board, Respondent represented that he had not been disciplined in another jurisdiction, when he had in fact been disciplined by the Arizona Board as of January 11, 2018.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Dishonesty)

14. Respondent's conduct as set forth in paragraphs 11-13 constitutes unprofessional conduct, dishonest acts, and knowingly signing a certificate or document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, and is cause for discipline pursuant to sections 2234, and/or 2234(e), and/or 2261 of the Code, in that Respondent represented to the Board on April 10, 2018 that he had not been disciplined in another jurisdiction, when he had in fact been disciplined by the Arizona Board as of January 11, 2018.

SECOND CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

15. Respondent is subject to disciplinary action under sections 2227, 2305 and 141 of the Code in that he deviated from the standard of care in regard to prescribing controlled substances to his patients, as found by the Arizona Board in its Decree of Censure and Order, as set forth in paragraphs 11-12 above.

CAUSE TO REVOKE PROBATION

(Violation of Probation Conditions)

16. The allegations of paragraphs 11-13 above are incorporated herein as if set out in full.

At all times after the effective date of Respondent's probation, Condition Five of the Board's Decision and Order in Case No. D1-2007-183501 provides that Respondent shall obey all federal state and local laws, and the rules governing medical practice in California.

17. At all times after the effective date of Respondent's probation, Condition Six of the Board's Decision and Order in Case No. D1-2007-183501 provides that Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether he is in compliance with the terms of his probation.

18. At all times after the effective date of Respondent's probation, Condition 11 of the Board's Decision and Order in Case No. D1-2007-183501 provides that failure to fully comply with any term or condition of probation is a violation of probation for which the Board may revoke probation and carry out the disciplinary order that was stayed, after giving Respondent notice and an opportunity to be heard.

19. Respondent's probation is subject to revocation because Respondent has violated Conditions Five and Six of his probation, as set forth above.

A. Respondent's probation is subject to revocation under Condition Five, because he violated Arizona law.

B. Respondent's probation is subject to revocation under Condition Six, because he submitted a Quarterly Declaration to the Board, signed on April 10, 2018, in which he checked "No" to the question of whether he had been disciplined in another jurisdiction. This statement was false at the time Respondent made it, because his Arizona discipline had become effective on January 11, 2018.

DISCIPLINE CONSIDERATIONS

20. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that Respondent has been subject to prior discipline, as follows:

A. On or about January 10, 2014, in a prior disciplinary action entitled "In the Matter of the First Amended Accusation and Petition to Revoke Probation Against Donovan John Anderson, M.D.," Case No. D1-2007-183501, the Medical Board of California revoked Respondent's Physician's and Surgeon's Certificate No. G 48061, stayed the revocation and

placed respondent on probation for five years, on terms and conditions that included a practice monitor. The 2014 Order supersedes the Board's October 29, 2009 Order in case #09-2007-183501, and was based on the Arizona Medical Board's June 4, 2009 Letter of Reprimand in Arizona Medical Board Case No. MD-08-0900A. The 2009 Arizona letter of reprimand was based on findings of fact involving deviation from the standard of care for examining a patient with chest pain, and keeping inadequate records. That Decision is now final and is incorporated by reference as if fully set forth.

B. On or about July 1, 2011, in a prior disciplinary action entitled "In the Matter of the Accusation Against Donovan John Anderson, M.D.," Case No. 16-2010-208984, the Medical Board of California revoked Respondent's Physician's and Surgeon's Certificate No. G 48061, stayed the revocation and placed respondent on probation for three years, on terms and conditions that included a practice monitor. The July 1, 2011 Order is based on the Arizona Medical Board's August 11, 2010 order issuing a letter of reprimand and placing Respondent on probation based on findings regarding Respondent's treatment of a diabetic patient from 2001-2009, in that over a period of years, Respondent failed to perform adequate laboratory monitoring, failed to refer the patient for yearly retinopathy evaluation, failed to perform a yearly foot examination, and failed to conduct appropriate initial and interval lab work when prescribing medication. That Decision is now final and is incorporated by reference as if fully set forth.

C. On or about September 19, 2007, in a prior disciplinary action entitled "In the Matter of the Accusation Against Donovan J. Anderson, M.D.," Case No. 16-2006-177004, the Medical Board of California issued a Decision which stated that a Public Reprimand was to be issued upon Respondent's completion of terms and conditions. On March 25, 2008, a Public Reprimand was issued against Respondent's Physician's and Surgeon's Certificate No. G 48061. The September 19, 2007 Order was based on the Arizona Medical Board's findings that Respondent discarded 100 patient records in a dumpster behind his office without regard to patient confidentiality, comprising unprofessional conduct. That Decision is now final and is incorporated by reference as if fully set forth.

D. On or about April 16, 2004, in a prior disciplinary matter entitled "In the Matter of the Accusation Against Donovan J. Anderson, M.D.," Case Number 16-2004-155197, the Medical Board of California issued a Decision which stated that a Public Letter of Reprimand was to be issued upon Respondent's completion of terms and conditions. The 2004 Order was based on the Arizona Medical Board's findings that Respondent, in January 2004, failed to obtain an adequately detailed patient history regarding blood in a patient's stool, failure to evaluate other causes of bleeding, failure to perform a rectal exam and inaccurately diagnosing allergies and fatigue as the cause of the bleeding. That Decision is now final and incorporated by reference as though fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking the probation that was granted by the Medical Board of California in Case No. D1-2007-183501 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. G 48061 issued to DONOVAN JOHN ANDERSON, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate No. G 48061, issued to DONOVAN JOHN ANDERSON, M.D.;

3. Revoking, suspending or denying approval of DONOVAN JOHN ANDERSON, M.D.'S authority to supervise physician's assistants and advanced practice nurses;

4. If placed on probation, ordering DONOVAN JOHN ANDERSON, M.D. to pay the Board the costs of probation; and

5. Taking such other and further action as deemed necessary and proper.

DATED:
November 20, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2018201546
21272643.docx

Exhibit A

Decision and Order

Medical Board of California Case No. D1-2007-183501

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation And Petition to Revoke Probation Against:	
DONOVAN JOHN ANDERSON, M.D.	**Case No. D1-2007-183501**
	OAH No. 2012100490
Physician's and Surgeon's Certificate No. G 48061	
Respondent.	

DECISION

The attached Proposed Decision is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on January 10, 2014.

IT IS SO ORDERED December 11, 2013.

MEDICAL BOARD OF CALIFORNIA

By: Barbara Yaroslavsky

Barbara Yaroslavsky, Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: DONOVAN JOHN ANDERSON, M.D., Physician's and Surgeon's Certificate No. G 48061 Petitioner.	Case No. D1-2007-183501 OAH No. 2012100490

PROPOSED DECISION

On September 3 through 6, 2013, in San Diego, California, Alan S. Meth, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Matthew M. Davis, Deputy Attorney General, represented complainant.

Michael Miretsky and Richard A. Wood, Attorneys at Law, represented respondent.

The matter was submitted on September 6, 2013.

FACTUAL FINDINGS

Jurisdiction

1. On August 7, 2013, Kimberly Kirchmeyer, Interim Executive Director of the Medical Board of California (hereafter, "Board"), filed First Amended Accusation and Petition to Revoke Probation No. D1-2007-183501 in her official capacity. Respondent had filed a timely Notice of Defense dated May 29, 2012. All new allegations were controverted by the Notice of Defense previously filed.

The First Amended Accusation and Petition to Revoke Probation alleged that respondent Donovan John Anderson, M.D. committed gross negligence and repeated

negligent act, was incompetent, was dishonest, excessively prescribed controlled substances, failed to perform appropriate prior examinations, made false statements, failed to maintain adequate or accurate records, and committed general unprofessional conduct in his care and treatment of three patients. Respondent provided emergency care to two of the patients in the emergency department of the Colorado River Medical Center (hereafter, "CRMC") during 2009 and 2010. Respondent provided care to one of the patients after she had been admitted to CRMC in July 2010. The First Amended Accusation and Petition to Revoke Probation alleged that respondent was on probation to the Board and in addition had been disciplined by the State of Arizona on four occasions.

License Status and History

2. On July 2, 1982, the Board issued Physician's and Surgeon's Certificate Number G 48061 to respondent. The certificate is current and will expire on November 30, 2013, unless renewed.

3. Respondent holds license number 13491 for the practice of allopathic medicine in the State of Arizona.

The Arizona Medical Board took the following disciplinary action against respondent's license:

a. On January 16, 2004, pursuant to a consent decree, respondent was issued a letter of reprimand for failing to conduct a complete physical examination, including a rectal examination on a patient, and for failing to refer the patient for further studies. The patient was later diagnosed with rectal cancer. Respondent was also ordered to pay a civil penalty in the amount of $1,000.00.

b. On June 9, 2006, following a formal interview, respondent was issued a letter of reprimand for improperly disposing of medical records.

c. On June 4, 2009, pursuant to a consent decree, respondent was issued a letter of reprimand for failing to perform an accurate history and physical examination. Respondent treated a patient who presented in the emergency department with complaints of chest and elbow pain, and respondent failed to document the patient's quality, duration, or reproducibility of pain; whether the pain was constant or intermittent; whether the pain was similar to the patient's prior myocardial infarction; and the patient's past medical history of myocardial infarction, stent placement, or elevated cholesterol. Respondent discharged the patient with a diagnosis of chest wall pain, but the documentation did not support this diagnosis. The patient returned to the emergency department five hours later with worsening chest pain and was admitted to the hospital, where a cardiac catheter showed 95 percent stenosis of the right coronary artery.

d. On August 11, 2010, following a formal interview, respondent was issued a letter of reprimand and placed on probation for one year on terms and conditions,

which included additional CME in the areas of recordkeeping and management of diabetes. Respondent began treating a patient in 2001, and the treatment continued until 2009 for various ailments. The Arizona Medical Board determined that respondent deviated from the standard of care by failing to perform appropriate diabetic lab monitoring of the patient, failing to refer the patient for yearly ophthalmology examinations to assess for diabetic retinopathy, failing to assure that the patient was referred and underwent yearly foot examinations on a diabetic patient, failing to perform yearly comprehensive foot examinations on the patient, and prescribing diabetic medications without appropriate initial labs or lab monitoring. These deviations may have contributed to the worsening of the patient's diabetic control and development of findings suggestive of diabetic neuropathy.

4. On April 16, 2004, the Board's Interim Executive Director advised respondent that the Board would issue a public letter of reprimand and a $1,000 administrative fine based upon a letter of reprimand issued by the Arizona Medical Board on January 16, 2004. The Board's Order issuing a Public Letter of Reprimand was dated May 7, 2004.

5. On July 7, 2007, respondent signed a Stipulation for Public Reprimand in the resolution of a disciplinary action that followed the issuance of the second Arizona Medical Board letter of reprimand on June 9, 2006. The settlement required respondent complete a medical record keeping course; submit a detailed written protocol for maintaining, presenting, storing, destroying and disposing of patient medical records; and pay an administrative fine of $2,000.00. The Board adopted the Stipulation as its Decision and Order, and it became effective on August 20, 2007. On March 25, 2008, the president of Board advised respondent that the Board had issued a Public Reprimand.

6. On July 10, 2008, the Executive Director of the Board filed an accusation against respondent alleging that respondent committed repeated negligent acts in his treatment of a patient at CRMC in 2007 and that he had been disciplined by the Arizona Medical Board. This was followed by the filing of first and second amended accusations. An administrative hearing was held on July 29 and 30, 2009. In a Proposed Decision dated August 20, 2009, the administrative law judge found that respondent engaged in a single act of simple negligence by ordering a skull series of plain x-rays rather than a CT of the head, and that this one act of simple negligence did not constitute cause for discipline under Business and Professions Code section 2234, subdivision (c), because it was not established that respondent committed repeated acts of negligence. The administrative law judge further determined that cause existed to impose discipline under Business and Professions Code section 2304 based upon the Arizona Medical Board's June 4, 2009, decision to issue a letter of reprimand to respondent. Consequently, the administrative law judge revoked respondent's license, stayed the revocation, and placed respondent on probation for five years on terms and conditions that included a requirement that respondent complete a PACE assessment course and an ethics course. The decision permitted respondent to petition for termination of probation upon successful completion of the PACE assessment course and ethics course because extending probation beyond successful completion of those courses would not better protect the public.

The Board adopted the Proposed Decision on September 16, 2009, and it was to become effective on October 19, 2009. The Board on October 15, 2009 issued a stay of execution of the decision for the purpose of allowing the Board time to review complainant's petition for reconsideration. The board took no action on the petition for reconsideration and it was deemed denied by operation of law on October 29, 2009.

7. The Board's Executive Director filed an accusation against respondent following the August 11, 2010, order of the Arizona Medical Board, which had provided for the issuance of a letter of reprimand and probation for one year. An administrative hearing was held on April 7, 2011. Respondent offered evidence at the hearing that he had taken the PACE recordkeeping course three times, had made a concerted effort to improve his practice, and had met all the terms and conditions of the October 2009 probationary order. Based upon this evidence, the administrative law judge proposed that respondent remain on probation for three years and the terms and conditions include a condition requiring the monitoring of his practice.

The Board adopted the Proposed Decision on June 1, 2011, and it became effective on July 1, 2011.

8. Respondent was born in Minnesota in 1954 and obtained a bachelor's degree with honors in science from Union College in Lincoln, Nebraska, in 1977. He received a medical degree from Loma Linda University Medical School in 1981. He completed a family practice internship at McKennan Hospital in Sioux Falls, South Dakota, in 1982, and moved to Needles, California, in July 1982 to fulfill a requirement of the National Public Health scholarship that he work in an underserved area.

Respondent became licensed to practice in California and Arizona in 1982 and has remained in the Mojave Valley area since then. The Mojave Valley is located on the banks of the Colorado River in California and Arizona and has a population of about 10,000, about half of whom live in Needles, the largest city in the area. Respondent began working at the Mojave Valley Health service with four other doctors primarily in the area of family practice, pediatrics, and obstetrics and gynecology. In 1986, respondent opened his own practice called the Willow Valley Medical Center about three miles from Needles. He closed it in 2011.

Respondent first obtained admitting privileges at CRMC in 1982 and worked there daily. He also had privileges at Western Arizona Regional Medical Center in Bullhead City for two years.

Respondent provides vital services to an underserved area. There were times when he was the only primary care physician there. The area's residents are not wealthy, and many are indigent. Many receive Medi-Cal, but none of the doctors in the area, including respondent, accept Medi-Cal patients. Respondent presently works in a rural health clinic located across from CRMC two days a week that is federally subsidized. He typically sees 25 to 30 patients a day. He is the only primary care physician working in the clinic and in the

Needles area. He still sees patient in CRMC.

In 1998, respondent began working in the emergency department of CRMC. He started with one 24-hour shift a week, but the number of shifts he worked increased over time. He generally worked weekends and holidays, and during 2009 and 2010, averaged working about one-third of the shifts. He generally worked 75 to 100 hours a week in the emergency department. There were about seven or eight other doctors who worked in the emergency department during 2009 and 2010. He remained there until December 2010 when he resigned.

CRMC is a 25-bed hospital and serves the residents living in the Mojave Valley and the many persons who vacation at the Colorado River. It generally has two to five patients. During 2009 and 2010, respondent was the sole attending doctor providing primary care services. He served as a hospitalist and was on-call all day every day. Respondent generally did rounds twice a day for patients in the hospital. Respondent has served as the chief of staff of the hospital, with the most recent term in 2009. Presently, he is one of only two physicians working at CRMC; the other is a cardiologist who comes there infrequently.

Respondent testified at the hearing that he took the PACE record keeping course in 1998 and 2006.

Patient D.T.

9. D.T. had lived in Needles for about 20 years but in 2010, lived in Calimesa, California. On July 16, 2010, she experienced flu symptoms and was dehydrated, and went to the emergency department of CRMC. Dr. Paget examined her at about 11:00 p.m. In the Clinical Impression section of the form used in the emergency department of CRMC, Dr. Paget circled volume depletion and vomiting/diarrhea, and wrote in "head ache." He admitted her to the hospital and transferred her care to respondent. He ordered IV fluids (200 cc. per hour), stool studies, clear liquids, and a number of medications. The notes indicate the patient was stable and mildly hypotensive. Dr. Paget believed she was depleted and needed fluid replacement. Dr. Paget did not contact respondent nor did he expressly order any nurse to contact respondent to inform him of the admission. Dr. Paget expected respondent would see the patient the next day.

D.T. was admitted to the hospital in the early morning hours of July 17, 2010. At about 4:00 a.m., the patient's blood pressure was low at 86/55. It increased over time, and the last reading at noon on July 18 was 106/69. Blood drawn in the emergency department was found to be normal, but blood drawn at 4:55 a.m. on July 17 following admission showed a low red blood count, a low hemoglobin, and a low hematocrit. They were also low at 4:30 a.m. on July 18, as was the white blood count.

Respondent did not see the patient on July 17. Respondent saw D.T. only once, on July 18. According to the nursing notes, that occurred at 3:30 p.m. D.T. was discharged shortly thereafter. Respondent did not perform a physical examination of D.T. on July 18.

He did not examine her arms, legs, rectum, abdomen, eyes, or ears, and did not listen to her heart or lungs.

10. Respondent wrote three progress notes, which he inserted into the patient's hospital chart. Partially opposite and above the date 7/16/10, respondent wrote an assessment of hypotension and gastroenteritis and a plan to admit, hydrate, and take stool cultures. He signed the note but did not time it.

The note respondent wrote dated 7/17/10 appears to be in a S.O.A.P. format. For subjective, respondent wrote that the patient was having less diarrhea and a CBC and lytes "wnl" (within normal limits). Under objective appear the letters "VSS," presumably vital signs stable, and afebrile. Respondent also wrote heart "RRR," meaning regular rate and rhythm. It appears respondent wrote lungs clear and abdomen benign. In the assessment section, respondent wrote "same." For the plan, respondent wrote "home in a.m." Respondent did not sign or time this note.

Respondent failed to note that the white blood count, hemoglobin, and hematocrit were low.

Opposite the date 7/18, respondent wrote "H & P done & on chart." He signed the note but did not time it.

11. Respondent completed a form document entitled "History and Physical Exam" on July 18, 2010, and signed but did not time it. It contains an entry for vital signs, including blood pressure, pulse, respirations, and temperature. The results respondent entered onto the form were the results obtained at approximately 4:00 a.m. on July 17, not those taken on July 18. For HEENT, respondent entered "clear." For heart/cardiovascular, respondent entered "R R R," for lungs. Respondent entered "clear," for abdomen. Respondent entered "benign," for rectum/genitalia. Respondent entered "patent," and for neurologic and extremities, respondent wrote "WNL." Respondent's impression was hypotension and gastroenteritis. The hypotension is consistent with the low blood pressure reading of July 16, but the patient's blood pressure was not low at the time respondent completed the form. Respondent did not enter the abnormal lab results of July 17 and 18.

12. Respondent testified at the hearing that he did not see D.T. on July 16 or 17. He explained that he was not notified by anyone on July 17 that she was present in the hospital and could have seen her that day if he had known she was there because he was at the hospital anyway. He testified he did see her during the afternoon of July 18, filled out the History and Physical Exam form, and completed the discharge instructions form and discharged her.

Respondent testified that when he saw D.T., she was stable and ready to be discharged. In completing the History and Physical Exam form, respondent testified he used the vital signs from the time she was admitted because it supported the decision to admit her, and was information that insurance companies reviewed. He testified that if the patient's

blood pressure was normal, that might not support a reason for her admission into the hospital. Respondent did not recall whether he listened to D.T.'s lungs and heart, but it was his usual practice to do so, and it was his usual practice to ask about the patient's abdomen and palpate. He testified he had no reason to check the patient's rectum because she had diarrhea, and there was no reason to check her genitalia. He further testified that he would not have done an extensive neurological examination.

Respondent testified he would normally complete the History and Physical Exam form at the time the patient was admitted. He indicated he knew the hospital's rule required it be done within 24 hours of admission, but since he did not see her within that time frame, he dated the form July 18 when he saw her.

Respondent testified he wrote the progress notes from information in the nursing notes and the chart. He testified he wrote them after July 18, 2010, when the chart was in medical records because he was told by someone in medical records that he had to write the notes. Respondent knew the rules required him to write progress notes every day.

13. The standard of care is to prepare medical records that are complete, accurate, dated, timed, and consistent with hospital policies and procedures. The standard of care is to document laboratory tests accurately in the medical records, interpret them correctly, and address any significant abnormalities. It is the standard of care to perform a history and physical examination within 24 hours of admission and to follow hospital policies and procedures. It is an extreme departure from the standard of care to falsify medical records.

14. Respondent's records relating to D.T. failed to meet the standard of care in the following respects:

a. The records were not timed and the July 17 progress note was not signed.

b. The records were not accurate. Respondent wrote progress notes dated July 16 and July 17 when he in fact did not see the patient on those days. He wrote the notes in such a way as to imply that he had seen the patient on those days instead of indicating that he was not present and that the information reflected in the notes came from the chart or other sources. He should have indicated when he in fact wrote the notes and then referred back to the date the note was designed to cover. Respondent entered lab results and vital signs that were not current but instead were a day or two old and did not indicate that the current vital signs showed that the patient had improved. Respondent recorded on July 17 that the CBC was within normal limits when in fact it was not, and he failed to document his thought process relating to the falling CBC results and the implications of low readings of white blood counts, hemoglobin, and hematocrit.

c. The records were false. Respondent documented progress notes for July 16 and 17 and implied he had seen the patient on those dates when in fact he had not seen her. Respondent recorded information in the History and Physical Exam form that

could have been obtained only by performing a physical examination, but he did not perform a physical examination on D.T. on July 18.

d. Respondent's History and Physical Exam form and his progress notes of July 17 and 18, 2010, documenting that he performed a physical examination when he in fact did not, are false and are extreme departures from the standard of care.

Overview of Treatment for S.M.

15. S.M. went to the emergency department of CRMC numerous times between April 2009 and April 2011 and was seen by respondent and other emergency department physicians for a variety of problems. In evaluating the care and treatment respondent provided to S.M. in the emergency department, complainant's expert reviewed the voluminous records from CRMC for the period June 14, 2009, to May 9, 2010, when S.M. was seen by respondent. Those records disclose the following information:

DATE	PRIMARY COMPLAINT OR CLINICAL IMPRESSION	MEDICATIONS OR PRESCRIPTIONS
6/14/09	Headache	Demerol 100 mg IM, Phenergan 50 mg IM, Bactrim
8/12/09	Low back pain	Percocet in ER orally, Percocet #36
8/15/09	Low back pain and migraine headache	Demerol 100 mg IM, Phenergan 50 mg IM, Percocet #36
8/20/09	Low back pain	Motrin
8/22/09	Low back pain, urinary tract infection	Demerol 100 mg IM, Phenergan 50 mg IM, Percocet #30
8/27/09	UTI	Cipro
9/7/09	Low abdominal pain, low back pain	Percocet #16
9/22/09	Upper respiratory infection	Demerol 100 mg IM, Phenergan 50 mg IM, Percocet #36, Phenergan with codeine
10/19/09	Opiate withdrawal	Darvocet #36, Detox centers list
11/15/09	Headache	Demerol 100 mg IM, Phenergan 50 mg IM
11/29/09	Low back pain	Demerol 100 mg IM, Phenergan 50 mg IM, Percocet #36
12/7/09	Toothache, bronchitis	Percocet #36, Amoxil
12/24/09	Dental pain	Demerol 100 mg IM, Phenergan 50 mg IM, Percocet #36
1/11/10	Anxiety, panic, abusive spouse	Xanax 1mg in ER, Xanax #40
1/17/10	Back pain	Percocet in ER orally, Percocet #36
1/23/10	Migraine headache, toothache	Demerol 100 mg IM, Phenergan 50 mg IM

1/31/10	Back pain, abdominal pain	Percocet in ER orally, Motrin in ER orally, Robaxin 750 mg #30, Indocin 50 mg #30
2/4/10	Anxiety, fibromyalgia, dysmenorrhea	Percocet in ER orally, Xanax in ER orally, Percocet #36, Xanax #30
2/11/10	Low back pain, fibromyalgia	Percocet in ER orally, Xanax in ER orally, Percocet #36, Xanax #30
2/27/10	Headache, neck pain, back pain	Percocet in ER orally, Toradol in ER orally
3/9/10	Dental pain	Morphine #36, Pen VK, Phenergan
4/1/10	Low back pain	Norco #36, Xanax #30
4/8/10	Gastroenteritis	Demerol 100 mg IM, Phenergan 50 mg IM, Loritab #36, Xanax #30, Doxycyline
4/15/10	Dental pain	Vicodin in ER, Norco #36, Soma 350 mg #40
4/29/10	Anxiety, back pain	Xanax in ER, Vicodin in ER, Xanax #30, Loritab #30
5/6/10	Headache	Demerol 100 mg IM, Phenergan 50 mg IM
5/9/10	Left ankle sprain	Vicodin in ER, Loritab #40

16. A Controlled Substance Utilization Review & Evaluation System (CURES) report of the patient prescription history of S.M. showed that between April 23, 2009, and April 9, 2011, S.M. received 73 prescriptions of controlled substances. Respondent wrote 25 of the controlled substances prescriptions, and 15 other practitioners wrote the remaining 48. Dr. Strecker, another emergency department physician, wrote 12 controlled substances prescriptions, and Dr. Shinn wrote 12 prescriptions. Other emergency department physicians who wrote prescriptions for controlled substances for S.M. were Dr. Paget (4 prescriptions), Dr. Kidd (1), Dr. Maier (2), Dr. Blumin (3), and Dr. Beckford (4).

17. Respondent performed very few laboratory studies or imaging studies of S.M. He ordered a UA & culture on August 22, 2009, for a urinary tract infection, an ankle x-ray for an ankle sprain on May 9, 2010, and x-rays of the cervical spine, sacrum, and coccyx following a fall.

18. On many occasion, respondent's notes of treatment he provided to S.M. at the emergency department do not contain examinations, assessments, histories, and plans for future treatment.

19. Physicians at the emergency department of CRMC use T-sheets to document the examinations they perform and their finding. These T-sheets are pre-printed forms with numerous entries on them, and the physician typically checks or circles positive or negative finding. The T-sheets are quick and easy to use, and, therefore appropriate in an emergency department setting. CRMC uses many different types of the form, depending on the reason

for the visit. Typically, a nurse after determining the reason for the visit, provides the treating doctor with the form that contains the information relevant for that visit.

20. On January 11, 2010, S.M. came to the emergency department of CRMC complaining of panic attacks. Respondent saw the patient and used two T-sheets to document the findings. On one of them, used for "Psych Disorder, Suicide Attempt, Overdose," respondent circled the word "agitated" for chief complaint, and circled the word "moderate" to describe the severity. Opposite the entry "situational problems," respondent wrote in the word "abusive." He then circled the work "spouse" below the entry for "abusive." In the area entitled "associated symptoms," respondent circled the word "agitated" and wrote in the word "panic" below it. Under past history, respondent wrote in the words "chronic pain." The other T-sheet was entitled "Physical Exam," respondent documented the physical examination he performed and wrote in the words "anxiety/panic" for his clinical impression. He also circled the word "patient" after the printed word "counseled" and sent her home as being "stable."

Respondent did not document anything else about this visit relating to what appears to be a complaint of spousal abuse. Later records do not contain information about the spousal abuse reported on January 11.

On May 9, 2009, respondent treated S.M. in the emergency department for an assault. He used the "Alleged Assault" T-sheet and indicated that the patient had hurt her back at the "River" with "fists" and "pushed down." He circled words to indicate the injury was to her "abdomen," and the pain "moderate." The nursing notes indicated that the San Bernardino County Sheriff's Department was contacted and two deputy sheriffs arrived to speak to the patient.

On November 7, 2010, S.M. came to the emergency department of CRMC complaining about "tailbone pain." Respondent documented that the patient had been "shoved onto pavement, landed on coccyx." The nursing notes indicate that the patient's boyfriend pushed her, and she hit her tailbone. The notes indicate the San Bernardino County Sheriff's Department was called to report the incident.

21. Respondent's documentation of his treatment of S.M. over the period of time he treated her in the emergency department of CRMC:

a. did not include laboratory monitoring such as liver functioning, EKG, and drug testing in spite of long-term opiods;

b. did not indicate any imaging in spite of long-term chronic pain;

c. did not indicate that respondent looked at past medical records or inquired as to whether the patient was obtaining medications from other providers;

d. did not include an exploration of the patient's heart rate when it

exceeded 100 on a number of visits to determine if the cause could be something other than chronic pain;

e. on October 9, 2009, the patient complained of pain in her hands but this was never explored by history, examination, or assessment;

f. did not include laboratory, drug, or EKG monitoring to evaluate long-term opioid medication safety;

g. did not include advice to the patient to stop smoking;

h. did not include details about past imaging, non-pharmaceutical consultations, and length of treatment;

i. did not include reference to the goals of treatment within the context of a chronic condition;

j. did not include a discussion of the risks and benefits of the controlled substance medication being prescribed or potential side effects;

k. included the administration of pain medication when the patient came into the emergency department on an unrelated issue, but there was no comment about pain, or when the examination was documented to be normal (September 22, 2009 and January 31, 2010);

l. on January 31, 2010 and September 7, 2009, the patient complained of pain in her abdomen, but this was never explored by history, examination, or assessment; and

m. on February 4, 2010, and October 9, 2009, the clinical impression was dysmenorrhea but there was no other information in the history or physical related to this.

22. Respondent treated S.M.'s chronic pain primarily by prescribing opiates over an extended period of time. Respondent did not obtain past medical records, seek out specific diagnoses for the symptoms, consider emergency department records, perform additional testing such as laboratory and imaging, consider or prescribe other non-opiate alternatives such as NSAIDs or tricyclic antidepressants that may have helped the patient's chronic pain, stop writing prescriptions for opioids despite suspecting the patient might be abusing the medications, and did not attempt other alternative non-addicting or less addicting medications or other treatments such as physical therapy. Respondent also did not seek advice from a subspecialist such as a pain management physician.

Overview of Treatment for R.R.

23. R.R. is 53 years of age and has lived in Needles for 15 years. He was first diagnosed with Ankylosing Spondylitis at age 16 and has been receiving SSI at the rate of

$940.00 a month since age 23. R.R. testified at the hearing and his appearance with his physical deformity confirmed that he is suffering from the condition. He testified he is in constant pain in his neck, hip, and back, and testified that he has had his hip replaced and his spine fused.

R.R. was under the care of Dr. Soto, a pain management physician, for about two to three years beginning in 2009. Dr. Soto was his primary physician, and he prescribed pain medications, including Vicodin and Methadone. Dr. Soto generally had R.R. take nine 10 mg. Methadone pills a day for a total of 90 mg. a day, and he would give R.R. a 30 day supply. The Methadone helped R.R. at first, but it affected his stomach and balance. Dr. Soto was the only physician in the Needles area who could treat his condition and would accept Medi-Cal.

Dr. Soto left his practice in Needles with only a short notice. R.R. tried to find another doctor to treat him, and sought help from Adult Protective Services. He tried California and Arizona physicians, but none would treat him. He does not have a car and can move about only with a wheelchair. R.R. decided that his only resource was the emergency department at CRMC. He only went there when he as in pain. He never followed up on referrals to doctors in San Bernardino because it was out of his reach.

R.R. saw about six physicians at CRMC and believed that respondent helped him by prescribing Methadone. He noted that respondent reduced the amount of his Methadone and eventually got him off it, although it was not easy. He then received prescriptions for Vicodin from other emergency department physicians. He eventually gave up going to the emergency department because it was so difficult and time-consuming and presently uses medical marijuana.

24. R.R. went to the emergency department of CRMC numerous times during 2009 and 2010 and was seen by respondent and other emergency department physicians for a variety of problems. In evaluating the care and treatment respondent provided to R.R. in the emergency department, complainant's expert reviewed the voluminous records from CRMC for the period August 20, 2009 to December 5, 2009. Those records disclose the following information:

DATE	PRIMARY COMPLAIN OR CLINICAL IMPRESSION	ER MEDICATIONS OR PRESCRIPTIONS
8/20/09	Neck pain	Demerol IM in ER, Phenergan IM in ER, Methadone 10 mg—3 tabs tid #90, Baciofen #40
9/3/09	Cervical radiculopathy, degenerative disc disease, myofascial strain	Vicodin in ER, Methadone 10 mg—3 tabs tif #100, Vicodin—4 times daily #36, Baciofen in ER
9/13/09	Ankylosing Spondylitis	Demerol IM in ER, Phenergan IM in ER,

		Methadone 10 mg—3 tabs tid #90, Vicodin—4 times daily #36
9/26/09	Neck and back pain	Demerol IM in ER, Phenergan IM in ER, Methadone 10 mg—3 tabs tid #90
10/12/09	Migraine headache	Demerol IM in ER, Phenergan IM in ER, Methadone 10 mg—3 tabs tid #90, Vicodin 5/500--R.R.30, Valium 10 mg--#30
10/21/09	Methadone dependency (seen by Dr. Blumin)	Toradol
10/22/09	Back and neck pain, Ankylosing Spondylitis	Demerol IM in ER, Phenergan IM in ER, Methadone 10 mg—3 tabs tid #60, Norco 10/325--#36, Valium 10 mg--#30
11/12/09	Migraine headache, Ankylosing Spondylitis	Demerol IM in ER, Phenergan IM in ER, Methadone 10 mg—3 tabs tid #90, Vicodin 5/500--#30, Valium 10 mg--#30
11/21/09	Neck pain	Demerol IM in ER, Phenergan IM in ER, Vicodin #30
11/25/09	Neck pain (seen by D. Blumin)	Toradol
11/27/09	Neck pain (seen by Dr. Maier at noon)	Percocet (small amount)
11/27/09	Back pain (seen by respondent at 8:00 p.m.)	Demerol IM in ER, Phenergan IM in ER, Methadone #60, Vicodin #36
12/5/09	Neck and back pain	Demerol IM in ER, Phenergan IM in ER, Methadone #60, Vicodin

25. A CURES report for the period of April 9, 2009, to March 30, 2011, disclosed that 49 prescriptions for controlled substances written for R.R. were filled. Respondent wrote his first prescription on for R.R. on August 20, 2009, after Dr. Soto, who had been providing care to the patient and prescribing Methadone, among other controlled substances, left the Needles area. R.R. filled prescriptions for Methadone, 10 mg, #270, written by Dr. Soto on April 20, May 20, and July 20, 2009. Dr. Paget, an emergency department physician, wrote a prescription for Methadone #270 which was filled on June 19, 2009. Respondent's first prescription for Methadone for R.R. was 30 tablets. Thereafter, respondent wrote prescriptions for Methadone for R.R. which were filled on September 3 (100), September 14 (90), October 12 (90), October 22 (90), November 13 (60), and December 18 (30). R.R. filled no other prescriptions for Methadone after December 18. Respondent wrote prescriptions for other narcotics for R.R. in addition to Methadone but only four after December 18. Dr. Maier also wrote a prescription for Methadone for R.R.

Of the 49 prescriptions for controlled substances written for R.R., respondent wrote 22. Dr. Kidd wrote five, and Dr. Soto four.

26. On October 21, 2009, Dr. Blumin treated R.R. for chronic neck pain and noted

Methadone dependency in the clinical impression. The note indicated that the patient was advised to go to the pain management clinic.

27. Respondent in treating R.R. over a period of time did not comply with Board guidelines for prescribing controlled substances in the following respects:

a. the documented history and physical was limited and consisted of many check-off boxes but did not contain details about past imaging, past non-pharmaceutical treatment, consultations, length of treatment and so forth;

b. respondent did not obtain prior medical records to understand past chronic pain evaluations and medication usage;

c. the goals of treatment were not documented and respondent did not put the goals of treatment in the context of a chronic condition;

d. respondent did not discuss the risks and benefits and side effects of prescribing controlled substances;

e. respondent by continuing to provide controlled substances removed the incentive for R.R. to seek care from a more appropriate provider;

f. respondent prescribed controlled substances after there were concerns about possible addictive issues;

g. respondent did not obtain laboratory or EKG monitoring;

h. respondent did not obtain imaging;

i. respondent did not look at past records; and

j. respondent did not order a drug screen to ensure the patient was taking the medication and not taking additional drugs.

In addition, respondent did not explore the patient's heart rate when it exceeded 100 on a number of visits. Respondent did not explore the pain in the patient's hands when he complained on October 12, 2009. Respondent did not evaluate for long-QT syndrome, and respondent did not advise or document an effort to stop the patient from smoking.

Complainant's Expert Witnesses

28. Complainant called two expert witnesses to testify in support of the allegations contained in the first amended accusation. The first was Clarke Lew, M.D. Dr. Lew is board-certified in Emergency Medicine and Family Practice. He is presently employed as an emergency department physician at Western Medical Center, where he handles a shift every

few months, and at an urgent care center. He attended UC Irvine, graduated in 1994, and then did an emergency medicine residency there until 2000. He was first licensed in 1995. He has served as an expert reviewer for the Board in approximately 10 cases.

29. The Board's expert on the issues relating to the patients S.H. and R.R. was Timothy Munzing M.D. Dr. Munzing obtained his medical degree from UCLA in 1982 and performed a residency in Family Practice at Kaiser for three years. He is board-certified in family practice. He presently works as a staff physician in family practice for the Southern California Permanente Medical Group (Kaiser) in Santa Ana. He has worked as a clinical professor in family practice at UCI. His patient load is about 550 patients, with about 10 percent of his practice devoted to patients with chronic pain. Dr. Munzing has been an expert for the Board for eight to nine years and has reviewed 45 to 50 cases.

Respondent's Expert Witnesses

30. Respondent called two expert medical witnesses. Howard Rosen, M.D., attended the New York Medical College and obtained his medical degree in 1979. He then did an internship in internal medicine at USC followed by a residency in anesthesiology at UCLA, completing it in 1982. He is board-certified in anesthesiology and pain medicine. He has been in private practice since 1982 and has specialized in pain management since 2001. He has lectured on emergency treatment and pain management and on new approaches in pain management. He has also lectured to doctors from rural areas. He has served as an expert in about ten civil cases and twice in administrative cases.

31. Stanley Kalter, M.D., attended USC Medical School, graduating in 1974 and did his internship and residency at Huntington Memorial Hospital in Pasadena. He is board certified in internal medicine and emergency medicine. He has practiced at Huntington Memorial for 35 years and has been the medical director of the emergency department since 1992.

32. Edward Paget, M.D., testified at the hearing although not in the capacity of an expert. He worked in the CRMC emergency department at the time respondent worked there. Dr. Paget attended medical school at the University of Oregon and did his residency at the Mayo Clinic. He entered the Air Force and worked as a surgeon at various bases and returned to the military and worked in an Army hospital in the South Pacific. He was a general surgeon in Needles from 1978 to 1997 and returned in 2006. At that time, he worked as a surgeon and part-time in emergency medicine. He is semi-retired now and works part time in the CRMC emergency department. He and respondent were the only two physicians who had admitting privileges to CRMC during 2009 and 2010.

Expert Opinions

33. Dr. Lew testified regarding the treatment respondent provided to D.T. He reviewed the hospital records and found that respondent committed several violations of the standard of care. He testified the standard of care required respondent to perform a history

and physical within 24 hours of the patient's admission to the hospital, and it was an extreme departure to falsify medical records. He testified that respondent's notes were not accurate and not timed, and that he should have indicated on the notes the date and time he wrote the notes instead of making it appear that they were written contemporaneously with the examination. He added that respondent should have indicated on the notes that he was not present and was writing the notes based on information contained in the record.

Dr. Lew concluded that respondent violated the standard of care in a number of respects. His conclusions were reasonable. While Dr. Kalter also testified about respondent's records, he did not dispute that respondent violated the standard of care in the way he wrote the notes. Dr. Lew's testimony was persuasive and established that respondent committed acts constituting simple and gross negligence.

34. Dr. Munzing wrote a lengthy and detailed report analyzing the care respondent provided to S.M. and R.R.. He found that respondent violated the standard of care in treating these patients in numerous ways, but the most egregious violations centered upon respondent's prescribing of pain medications to the two patients. Dr. Munzing relied in part upon the Board's published guidelines as well as his knowledge and training and experience in the area of family practice in a busy urban area. He continually pointed to the fact that respondent simply addressed the patient's pain and never addressed the underlying causes of the pain.

35. Dr. Munizing concluded that respondent in treating R.R. failed to appropriately monitor the patient while prescribing opiates, failed to monitor the patient for side effects and to perform periodic appropriate reviews of the use of opiates, failed to enforce consultation as a requirement for continued opiate prescribing, and continued to prescribe opiates when he became suspicious of addiction. He believed these violations were an extreme departure from the standard of care.

Dr. Munzing also found an extreme departure from the standard of care in respondent's treatment of R.R. when he failed to appropriately evaluate and periodically re-evaluate in spite of chronic pain treatment failure, when he failed to refer the patient to a pain management specialist or other subspecialist to treat the patient's pain, and when he failed to consider and try other alternative non-addicting or less addicting medications as well as non-pharmaceutical treatments.

Dr. Munzing wrote in his report and testified that respondent's failure to perform and document an adequate history and/or physical examination on multiple visits, and the failure to perform and document appropriate monitoring of long-term opioid treatment were simple departures from the standard of care. He also found a simple departure from the standard of care in respondent's use of opioids for pain without evaluating the pain further through imaging modalities and without referring and documenting a referral for further evaluation.

36. Dr. Munzing concluded that respondent committed an extreme departure from the standard of care in treating S.M. by failing to monitor the patient while prescribing

opiates, failing to monitor her for side effects, failing to perform periodic appropriate review of the use of opiates, failing to enforce consultation as a requirement of continued opiate prescribing, and continuing to prescribe controlled substances when he became suspicious of addiction. He also pointed to respondent's failure to appropriately evaluate and periodically re-evaluate in spite of chronic pain treatment failure, his failure to refer the patient to another specialist, and his failure to try alternative non-addicting or less addicting medications and non-pharmaceutical treatments.

Dr. Munzing found simple departures from the standard of care in respondent's failure to perform and document an adequate history and/or physical examination of multiple visits, his failure to perform and document appropriate monitoring of long-term opiate treatment, his failure to document adequately, and the failure to explore the issue of an abusive spouse.

37. Dr. Kalter and Dr. Rosen addressed each and every point raised by Dr. Munzing and disagreed with Dr. Munzing. They both found respondent did not violate the standard of care in any respect. In particular, Dr. Rosen, a pain management specialist, found respondent acted appropriately in the way he prescribed pain medications for the two patients.

Evaluation

38. The central point that Dr. Munzing made, and which formed the basis for all of his opinions, is that if an emergency room physician sees a patient over a long period of time, the emergency room physician in effect becomes a primary care physician, and even if the physician sees the patient in an emergency department, that does not relieve the physician of treating the patient as if he or she were a primary care physician. Dr. Munzing did not believe that respondent should have been held to the standard of care of a pain specialist but felt that his management of patients with chronic pain required him to treat the patients as if they were his primary care patients. Dr. Munzing did not specify when the transformation from an emergency room patient to a primary care patient took place but indicated that one or two visits did not transform the relationship, while the numerous times respondent saw these patients resulted in this change in relationship. He therefore criticized respondent for handling each visit in isolation rather than as part of a larger chronic pain issue. Following Dr. Munzing's line of reasoning would therefore result in a determination that several other emergency department physicians would also have been considered primary care physicians of S.M. and R.R. because those physicians saw those patients on multiple occasions as well.

Three emergency department physicians testified in this proceeding, including respondent, and each of them testified that the primary, if not exclusive role, of an emergency department physician is to treat the complaint that brought the patient into the emergency department. According to Dr. Kalter, an emergency department physician is required to treat the acute pain and leave the chronic pain to another doctor because emergency department physicians do not do long term care. He added that patients appear in emergency departments periodically and without appointment, and want the specific problem that brought them in to be treated. He explained that Dr. Munzing connected "the dots," in other

words, each independent visit to the emergency department, and connected them to form a continuous line of treatment. But Dr. Kalter believed that emergency department physicians do not connect the dots and instead treat each visit separately.

In addition, Dr. Rosen testified he did not consider respondent as a long-term provider but instead as a physician treating "flareups."

The conclusion is inescapable that Dr. Munzing did not have the expertise to conclude that respondent should have treated S.M. and R.R. as if they were long-term primary care patients. He is board-certified in family practice and was well qualified to offer opinions in his field. However, he testified outside his field of expertise. He was not qualified to offer an opinion that respondent working as an emergency department physician should have treated the two patients as if they were primary care patients in a setting where other medical services were readily available, such as his Kaiser practice in Santa Ana. Respondent treated these indigent patients in an underserved environment, with few resources available to assist him. Dr. Munzing had no expertise with an emergency department practice, much less one in this environment. Accordingly, it must be concluded that Dr. Munzing's opinions carry insufficient weight to establish by clear and convincing evidence to a reasonable certainty that respondent violated the standard of care of an emergency department physician in his treatment of S.M. and R.R.

39. There is one opinion offered by Dr. Munzing that specifically must be addressed, and that relates to respondent's failure to further explore the note of abuse in S.M.'s visit on January 11, 2010. As a mandated reporter, respondent was required to report instances of suspected patient abuse to proper authorities, and on this occasion, he did not. The question, however, is whether there was any physical, mental, or emotional abuse perpetrated on S.M. There are no physical findings suggestive of physical abuse noted by way of circling or checking some word, and respondent wrote nothing in by hand. Respondent relies upon the absence of any other entry to argue that the patient did not complain specifically of physical, mental, or emotional abuse. That is a relatively weak reed upon which to base a finding. Nevertheless, the records introduced in this proceeding document two other occasions when respondent did contact law enforcement when he learned that S.M. had been abused.

Clearly respondent should have documented and explained the entry of abuse, and it is difficult to accept that respondent would have done so only if there was some abuse. It may have been a documentation error, but it may not have been. Respondent should not have let the record be silent. His failure to properly document and explain the word "abusive" in the record is a simple violation of the standard of care. It is appropriate to rely upon Dr. Munzing's opinion on this issue, and his opinion is persuasive.

Character Evidence

40. No witness testified specifically about respondent's character and ability as a physician, but Dr. Paget's testimony should be considered. He testified that there are no

primary care physicians in the Needles area except respondent, and described the patients who went to the federally-subsidized clinic as indigent who had no opportunity to obtain other medical treatment. He testified that if respondent lost his license, that would be disastrous for the community because there was no one else to provide care. He agreed that more doctors were needed, but at present, there were none.

LEGAL CONCLUSIONS

1. Business and Professions Code section 2234 provides in part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> ...
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

2. The purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Ettinger v. Board* of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856.)

The standard of proof in an administrative disciplinary proceeding seeking to suspend or revoke a professional license is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance*, *supra*, at 856.) Guilt must be established to a reasonable certainty, and it cannot be based on surmise or conjecture, suspicion, or theoretical conclusions, or uncorroborated hearsay. (*Pettit v. State Board of Education* (1973) 10 Cal.3d 29, 37.) The obligation to establish charges by clear and convincing evidence is a heavy burden. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

3. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.) The process of deriving a standard of care necessarily requires some evidence of an ascertainable practice. (*Johnson v. Superior Court* (143 Cal. App. 4th 297, 305.)

4. The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052. Simple negligence is merely a departure from the standard of care. Incompetence has been defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." *Id.* at 1054.

5. Business and Professions Code section 725 provides in part:

> (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist."

6. Business and Professions Code section 2242 provides in part:

> "(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022, without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

7. Business and Professions Code section 2261 provides:

> Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

8. Business and Professions Code section 2266 provides:

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

9. Cause to impose discipline on respondent's medical license pursuant to

Business and Professions Code section 2234, subdivision (b), gross negligence, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T., was established by reason of Findings 9 through 13, 14d, and 34.

10. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (c), repeated negligent acts, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T. and S.M., was established by reason of Findings 9 through 14, 34, and 40.

11. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (d), incompetence, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T., was not established. Dr. Lew did not testify or offer an opinion that respondent's conduct relating to his record keeping was incompetent, and no other evidence of incompetence was introduced into evidence.

12. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (e), dishonesty or corruption, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T., was established by reason of Findings 9 through 14, and 34.

13. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code sections 2234 and 2261, making false statements, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T., was established by reason of Findings 9 through 13, 14, and 34.

14. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code sections 2234 and 2266, failure to maintain adequate and accurate records, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T., was established by reason of Findings 9 through 13, 14, and 34.

15. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, unprofessional conduct, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of D.T., was established by reason of Findings 9 through 14, and 34.

16. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (b), gross negligence, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

17. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (c), repeated negligent acts, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

18. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (d), incompetence, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

19. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, unprofessional conduct, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

20. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code section 725, excessive prescribing, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

21. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code sections 2234 and 2242, failure to perform an appropriate prior examination before prescribing controlled substances, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

22. Cause to impose discipline on respondent's medical license pursuant to Business and Professions Code sections 2234, and 2262, failure to maintain adequate and/or accurate records, and to revoke respondent's probation for failure to obey all laws, for his care and treatment of S.M. and R.R., was not established by reason of Finding 39.

23. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines states

> Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 11th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.
>
> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to

undertake Board- ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

24. For each of the violations established relating to respondent's record keeping of D.T.'s treatment, the Board's disciplinary guidelines provide for a minimum penalty of a stayed revocation with a probationary period of five years and a maximum penalty of revocation.

Respondent has a lengthy disciplinary history. He has had four disciplinary cases brought against his Arizona license, and each of them was sustained and resulted in some form of discipline. The first three were letters of reprimand, and the final matter resulted in a one-year period of probation. His California disciplinary history tracked the Arizona cases and were based on those violations. His first two cases resulted in letters of reprimand that were issued without hearings. The second letter of reprimand issued in 2008 required respondent to take a medical record keeping course. In the first California case that went to hearing, an additional charge of repeated negligent acts was made, but the Board determined that respondent committed only one negligent act and that was insufficient to impose discipline. Respondent is on probation in California following the second administrative hearing, with probation having started on July 1, 2011.

Respondent's violations in this case resulted from his record keeping, and he has had that problem in the past in Arizona. The Arizona Medical Board in fact required respondent to take additional CME in medical record keeping in its last disciplinary order in 2010 as did the Board. Respondent has taken the PACE record keeping course two or three times.

Respondent's violations are serious but have not resulted in any patient harm. It does not appear that D.T. required further medical care following her hospitalization in Needles in July 2010 and therefore the false and erroneous records respondent created were never relied upon for further treatment. It further appears that respondent has not learned much from the record keeping courses he has taken.

Respondent committed the violations more than three years ago.

It is a close question whether the violations established in this proceeding, coupled with respondent's prior disciplinary record, should result in the revocation of his license. The factor that tips the balance in favor of probation, however, is respondent's role in providing medical care to the community in which he resides. Respondent has worked in the Needles area for more than 30 years and currently is the only primary care physician providing care to indigent patients through the federal clinic where he works. He is also the only primary care physician working at CRMC. According to Dr. Paget, losing respondent's medical services would be disastrous for the Needles community. The public would

therefore be seriously harmed if respondent's license were revoked. In this unique situation, the risk posed to the public in allowing respondent to continue to practice medicine in light of his history of repeated record keeping violations is outweighed by the public's need for his medical services in the Needles area. Accordingly, the most appropriate disciplinary order is a stayed revocation and continued probation.

The Board's 2007 Stipulated Public Reprimand included a requirement that respondent take a medical record keeping course and submit an office protocol for medical records to the Division of Medical Quality. The Board's 2009 disciplinary order placing respondent on probation required him to take the PACE clinical training course and an ethics course. The 2011 probationary order imposed a condition of monitoring. It should be noted that the acts that respondent committed in this case occurred before the 2011 disciplinary order became effective. While respondent last took a record keeping course following the 2007 disciplinary action, the requirements of accurate and honest record keeping need to be reinforced, and therefore, requiring him to take the course again is appropriate, as is continuation of the monitoring requirement. Requiring him to take a clinical training course and an ethics course again is unnecessary.

ORDER

Physician's and Surgeon's Certificate No. G 48061 issued to respondent Donovan John Anderson, M.D., is revoked. However, the revocation is stayed, and respondent is placed on probation for five years upon the following terms and conditions[1]:

1. Monitoring--Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring

[1] This disciplinary order shall supersede any present disciplinary order.

plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom

component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

5. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. General Probation Requirements

Compliance with Probation Unit
Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes
Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice
Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal
Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training

program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

10. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: October 4, 2013

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings

EXHIBIT B

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2707

I, Mary Bober, of the Arizona Medical Board, hereby certify that I am the official custodian of the records of the agency; and that the attached documents are true and complete copies of the documents requested regarding:

Physician Name: Donovan J. Anderson, M.D.

License Number: 13491

Attached are the following document(s):

Document Name:
Physician Profile

Findings of Fact, Conclusions of Law and Order for Decree of Censure, Practice Restriction and Probation
Dated: December 7th, 2017 (Effective January 11th, 2018)

Order for Decree of Censure and probation; and Consent to the Same
Dated: April 6th, 2017

Document # 19 of Pages:

Dated this 2nd day of February, 2018

ARIZONA MEDICAL BOARD

Mary Bober

Mary Bober
Custodian of Records

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DONOVAN J. ANDERSON, M.D.** Holder of License No. 13491 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-17-0235A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR DECREE OF CENSURE, PRACTICE RESTRICTION AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 3, 2017. Donovan J. Anderson, M.D. ("Respondent"), appeared with legal counsel, Michael J. Ryan, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 13491 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0235A after receiving a complaint regarding Respondent's care and treatment of a 36 year-old male patient ("CH") alleging inappropriate prescribing and failure to properly treat the patient.

4. Respondent provided primary care services to CH to address chronic pain, anxiety and sleep disruption. During the course of treating CH, Respondent prescribed opiates, benzodiazepines, zolpidem and Carisoprodol.

5. According to the Controlled Substance Prescription Monitoring Program ("CSPMP"), Respondent first prescribed alprazolam 1mg #90 on April 18, 2016. CH had recently obtained and filled prescriptions for hydrocodone and zolpidem from other

prescribers. Two other prescriptions for alprazolam written by Respondent on April 18, 2016 were filled by CH in May and June, 2016.

6. On July 1, 2016, Respondent prescribed CH alprazolam 1mg #100 with one refill that CH filled on July 6, 2016. On June 13, 2016, CH filled a prescription for alprazolam #20 that had been written by Respondent on April 18, 2016. On July 18, 2016, CH filled a #90 prescription for alprazolam that had been prescribed by Respondent on June 6, 2016.

7. On August 9 and September 14, 2016, Respondent prescribed CH hydrocodone 10mg #120 and Carisoprodol 350mg #100. Respondent subsequently referred CH to a pain specialist who continued the prescriptions. Respondent continued to prescribe CH alprazolam.

8. The standard of care required Respondent to document all prescribers of controlled substances, have the patient enter into a pain contract, perform urine drug screen monitoring, review the CSPMP database, utilize non-controlled substance therapies, and obtain informed consent from the patient regarding the single use and interacting dangers of agents being prescribed. Respondent deviated from this standard of care by failing to document all prescribers of controlled substances, by failing to have CH enter into a pain agreement, by failing to perform urine drug screen monitoring, by failing to review the CSPMP database, by failing to utilize non-controlled substance therapies, and by failing to obtain informed consent with the patient regarding the single use and interacting dangers of agents being prescribed.

9. Actual harm occurred to the patient in that CH experienced progressive habituation to opiates and sedative hypnotics.

10. There was the potential for patient harm in that CH was at risk for worsening of sleep disturbances identified by the pain specialist rather than pursuit of the underlying sleep problem.

11. During a Formal Interview on this matter, Respondent testified that when CH first presented to Respondent's office, he was a new patient. Respondent initially concluded that CH had an acute, self-limiting problem that would resolve.

12. Respondent also testified regarding the actions he had taken to comply with the Board's Order in case MD-15-0691A, including completion of continuing medical education ("CME") in medical recordkeeping and obtaining a practice monitor. Respondent presented a letter from the practice monitor regarding Respondent's progress while under monitoring, and requesting that he be allowed to continue to work with Respondent to improve his documentation and prescribing practices.

13. During that same Formal Interview, Board members commented that Respondent has had previous Board investigations that have resulted in discipline, but that the remediation ordered by the Board in case MD-15-0691A seems to have caused changes in practice that may alleviate concerns regarding Respondent's medical recordkeeping. Board members agreed that Respondent has been in compliance with that Order. Board members further commented that concerns remained regarding Respondent's controlled substance prescribing and discussed limiting Respondent's prescribing to inpatient hospital and hospice settings, for a period of ten years.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.
2. Respondent is placed on Probation for a period of 10 years with the following terms and conditions:

a. **Practice Restriction**

Respondent's practice is restricted in that he shall not prescribe controlled substances except as stated herein for the duration of this Probation. Respondent may prescribe controlled substances only in an inpatient hospital or hospice setting, including prescribing discharge controlled substance medications to a patient for up to five days. Respondent shall provide a copy of this Order to the Practice Monitor in case MD-15-0691A and cause the Practice Monitor to provide the Board with written notification that the Practice Monitor has received this Order. On a monthly basis, Respondent shall provide the Practice Monitor with a copy of his CSPMP report for the Practice Monitor's review.

b. **Obey All Laws**

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

c. **Tolling**

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

d. **Probation Termination**

Respondent may not request termination of this Order no sooner than five years from its effective date. Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 7th day of December, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 7th day of December, 2017 to:

Michael J. Ryan, Esq.
Ensign Services Inc
2024 S Marble St
Gilbert, AZ 85295-5584
Attorney for Respondent

ORIGINAL of the foregoing filed this 7th day of December, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Bailey

Board staff

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DONOVAN J. ANDERSON, M.D.** Holder of License No. 13491 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-15-0691A **ORDER FOR DECREE OF CENSURE AND PROBATION; AND CONSENT TO THE SAME**

Donovan J. Anderson, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for a Decree of Censure and Probation; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 13491 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-15-0691A after Respondent disclosed on his 2015 license renewal application that the California Medical Board ("CMB") took action against his California medical license.

4. On January 10, 2014, after a hearing on the merits, the CMB issued an Order for five years of stayed revocation probation arising out of Respondent's care and treatment of three patients. With regard to patient D.T., the CMB sustained findings that Respondent wrote progress notes on days when Respondent did not see D.T., entered vital signs that were not current and otherwise failed to accurately document his care and treatment of the patient. With regard to patient S.M., the CMB sustained findings that Respondent treated S.M.'s chronic pain by prescribing opiates over an extended period of time, without obtaining past medical records, seeking out specific diagnoses for claimed

symptoms, performing appropriate additional testing and laboratory work, considering non-opioid treatment alternatives, and failing to take action to address concerns of opioid abuse or diversion. With regard to patient R.R., the CMB sustained findings that Respondent failed to comply with CMB guidelines for prescribing controlled substances in that Respondent failed to include a detailed history and physical assessment, failed to obtain prior medical records, failed to document the goals of treatment, failed to discuss the risks, benefits and side effects of prescribing controlled substances, prescribing controlled substances after concerns about possible addiction, failed to obtain appropriate tests and imaging, and failed to conduct appropriate drug screens.

5. The CMB issued Respondent an Order for Stayed Revocation and placed his California medical license on probation for 5 years, the terms of which included practice monitoring or taking the professional enhancement program offered by the Physician Assessment and Clinical Education ("PACE") Program, University of California, San Diego School of Medicine, as well as taking the PACE medical record keeping course.

6. Based on the CMB Order, on December 10, 2015, the Board entered into an Interim Consent Agreement for Practice Restriction with Respondent pursuant to which Respondent was required to complete a competency evaluation. On May 16-20, 2016, Respondent underwent a competency evaluation through PACE. The PACE evaluators found deficiencies in Respondent's current knowledge base, his medical decision making and clinical judgment. Respondent's PACE evaluators made several recommendations for Respondent to remediate the deficiencies, which included the following:

a. Practice monitoring to help Respondent improve his medical recordkeeping, medical knowledge of current guidelines, and physical examination skills;

b. Take twice the amount of required annual continuing medical education ("CME");

c. Attend a medical recordkeeping course;

d. Undergo a comprehensive fitness for duty neuropsychological evaluation; and

e. Follow up with his primary care physician and/or cardiologist to address some health concerns and follow through with any treatment or recommendations;

7. On October 12, 2016, Respondent underwent a neuropsychological examination. The evaluating physician opined that it was within a reasonable degree of neuropsychological certainty that Respondent has the ability to safely and effectively practice medicine provided that he engages in further healthcare assessment and treatment to address some weaknesses identified in the evaluation and complies with the PACE recommendations and the terms of the CMB Probation. The evaluating physician also recommended that Respondent undergo a comprehensive medical examination and comply with any treatment recommendations and engage in psychotherapy.

8. Respondent's prior disciplinary history with the Board includes a Letter of Reprimand and Civil Penalty in MD-03-0319A for, in part, failure to conduct a complete physical exam, a Letter of Reprimand in MD-08-0900A for failure to perform an accurate history and physical examination during a patient's initial emergency department visit and for inadequate medical records, and a Letter of Reprimand with One Year Probation in MD-09-1540A for failure to properly assess and monitor a diabetic patient. The Probation included a requirement that Respondent obtain CME in medical recordkeeping and an intensive course for the management of diabetes.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(o)("Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine or the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. The action taken may include refusing, denying, revoking or suspending a license by that jurisdiction or a surrendering of a license to that jurisdiction, otherwise limiting, restricting or monitoring a licensee by that jurisdiction or placing a licensee on probation by that jurisdiction.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. Respondent is placed on Probation for a period of five (5) years with the following terms and conditions:

a. **Continuing Medical Education**

Respondent shall within 6 months of the effective date of this Order obtain no less than 15 hours of Board staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding medical recordkeeping. Respondent shall within thirty days of the effective date of this Order submit his request for CME to the Board for pre-approval. The medical recordkeeping CME ordered herein shall be different from the CME course(s) Respondent previously completed pursuant to prior orders

imposed by the California and Arizona Medical Boards. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure.

b. **Continuing Medical Education Required for Biennial License Renewal**

Respondent shall obtain no less than 40 CME hours per year for the duration of Probation as a requirement for the biennial renewal of Respondent's medical license. At least five of the 40 CME hours shall involve the evaluation and management of diabetes.

c. **Board-Approved Psychotherapist**

Respondent shall immediately enter treatment with a Board-approved psychotherapist as recommended by his neuropsychological evaluator and shall comply with any and all treatment recommendations. The psychotherapist shall be experienced in the assessment and treatment of individuals with behavioral health conditions. Respondent shall meet with the psychotherapist at least weekly for four consecutive weeks following the effective date of this Order and then twice a month for eleven months to address any behavioral health concerns. Respondent shall instruct the treating psychotherapist to submit written reports to Board staff regarding Respondent's diagnosis, prognosis, current medications, recommendation for continuing care and treatment, and ability to safely practice medicine. The first report shall be submitted within 30 days following the completion of the first four consecutive weeks of psychotherapy and thereafter, the reports shall be submitted quarterly to Board staff for the duration of the psychotherapy. Respondent shall pay the expenses of the psychotherapy and is responsible for paying for the preparation of the reports. Respondent shall authorize the psychotherapist to communicate with Board staff regarding Respondent's compliance with

treatment, and if at any time the psychotherapist finds evidence that Respondent is a safety threat to patients.

d. **Medical Examination and Treatment**

Within 60 days from the effective date of this Order, Respondent shall undergo a comprehensive medical examination by a Board-approved physician and follow any treatment recommended by the physician. Respondent shall sign all necessary releases authorizing the physician to provide all medical records and information relating to the examination and treatment to the Board. Respondent shall instruct the physician to submit a report to the Board of the findings of the medical examination and any recommended treatment for Respondent.

e. **Chart Reviews**

During the term of Probation, Respondent shall be subject to chart reviews, on a quarterly basis, conducted by the Center for Personalized Education for Physicians ("CPEP") in Denver, Colorado. Respondent shall bear all costs associated with the chart reviews. Based upon the chart reviews, the Board retains jurisdiction to take additional disciplinary or remedial action. The chart reviews shall commence upon proof of Respondent's successful completion of the Board ordered CME in recordkeeping, and shall involve current patients' charts. The Board retains the right to conduct random chart reviews of Respondent's patients in addition to those conducted by CPEP.

f. **Practice Monitor**

Within 30 days of the effective date of this Order, Respondent shall submit the name of a practice monitor who is a physician licensed and in good standing with the Board. The practice monitor shall be responsible for ensuring that Respondent's treatment is in accordance with current guidelines and that Respondent is demonstrating appropriate physical examination skills. Respondent shall agree to allow the monitor to view his

interactions with any and all patients as deemed appropriate by the monitor. The monitor shall provide written reports to the Board on a monthly basis or at any time the monitor has concerns regarding Respondent's safety to practice. Respondent shall be responsible for all expenses relating to the practice monitor and preparation of the monthly reports to the Board. After 12 consecutive favorable reports from the monitor, Respondent may petition the Board in writing for termination of this requirement. Respondent's request for termination must be accompanied by a report from the practice monitor that Respondent's fund of knowledge regarding current treatment guidelines is adequate and his physical examinations meet the standard of care.

g. **Obey All Laws**

Respondent shall obey all state, federal and local laws, all rules governing the *practice* of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

h. **Tolling**

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

i. **Probation Termination**

After the expiration of three years of the Probation period, Respondent may petition the Board to terminate the Probation. Respondent's request to terminate the

Probation shall be accompanied by correspondent from Respondent's psychotherapist regarding Respondent's ability to safely practice. The request shall also include at least three consecutive satisfactory reviews from the CPEP Practice Monitoring Program. Respondent's request for release will be placed on an upcoming Board agenda, provided a complete submission is received by Board staff no less than 14 days prior to the scheduled Board meeting. Respondent's request for termination must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

4. This Order supersedes all previous consent agreements and stipulations between the Board and/or the Executive Director and Respondent in case MD-15-0691A, and is the final resolution of this matter.

DATED AND EFFECTIVE this 6th day of April, 2017.

ARIZONA MEDICAL BOARD

By Patricia E McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.") and 32-1451.

11. ***Respondent has read and understands the conditions of probation.***

Donovan J Anderson MD DATED: 3/1/17

DONOVAN J. ANDERSON, M.D.

EXECUTED COPY of the foregoing mailed this 6th day of April, 2017 to:

Scott Holden
Holden & Armer, P.C.
4505 E Chandler Blvd Ste 210
Phoenix, Arizona 85048-7688
Attorney for Respondent

ORIGINAL of the foregoing filed this 6th day of April, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Baker

Board staff